DR. NYHAN: *Something that has been bothering me you alluded to earlier. Dr. James Cherry has recently reported in* Pediatrics[4] *what looked to me like a controlled study on racemic epinephrine and as I remember reading it, he could not tell the control from the treated. Do you have a comment on that study?*

DR. HARWOOD: Yes. The controlled part of that study involved twenty patients. The number seemed to me to be inadequate. He did not state whether patients that did poorly and did not respond to racemic epinephrine had epiglottitis. There was no information as to which disease entity he was treating. This was what prompted the questionnaire from Dr. Adair. He was inquiring about experience in treating epiglottitis, and he did not expect them to respond.

QUESTION FROM THE AUDIENCE: *Would you treat a patient with epiglottitis with ampicillin?*

DR. HARWOOD: I believe that epiglottitis is caused by Hemophilus influenzae. Today the drugs of choice are ampicillin and chloramphenicol.

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Repeated Taps vs. Craniotomy for Subdural Hematomas

For a number of years neurologists interested in this particular field have questioned the value of craniotomy and the extensive use of surgical procedures recommended in the past and stemming largely from the experience of neurosurgeons . . . The operation itself, which is a very extensive and traumatic operation, cannot possibly remove all the membranous material and clotted blood that make up a chronic subdural hematoma. One can achieve as much by multiple aspirations of fluid from the subdural space, carrying out a subdural tap whenever there is a sign of increased pressure, such as fullness of the fontanelle or vomiting or the sudden onset of fever to suggest that enough fluid has accumulated to justify another tap. And so we now have two schools of thought—the original one consisting of the craniotomy and the second one consisting of tapping repeatedly until fluid is no longer attained. The group advocating the repeated taps will admit that a certain percentage of children will continue to show fluid with repeated tapping and that this is finally treated by setting up or establishing a shunt from the subdural space so that fluid will continually discharge from this space until the brain expands to fill the space and fluid formation comes to an end. I personally think that the data that are accumulating in this particular field strongly suggest that repeated tapping is as successful, if not more so, than the craniotomy and I believe that more and more neurosurgeons are being won over to the medical (if you can call it medical) approach with repeated taps than by extensive use of surgical operation.

—SYDNEY S. GELLIS, MD, *Boston*

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